GENERAL UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under the provisions of state law, the Department of Medical Assistance Services (DMAS) must provide for the continuing review and evaluation of the care and services paid through SLH, including review of the utilization of the services of providers and by recipients. This function is handled by the Division of Program Operations of the Department of Medical Assistance Services.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. Computerized exception reports for providers are developed by comparing an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. For recipients and providers who exceed the peer group averages by at least two standard deviations, an exception report for this activity is generated.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of SLH reimbursement. The Department utilizes a scientific random sample of paid claims for a 15-month audit period to calculate any excess payment. The number and amount of invalid dollars paid in the audit sample are compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample.

Providers must refund payments made by SLH if they are found to have billed DMAS contrary to policy, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by DMAS personnel with detailed

instructions. This will also apply when information is requested about a recipient.

HOSPITAL UTILIZATION REVIEW

INTRODUCTION

All hospitals have in place a utilization review plan to ensure that the services provided to State/Local Hospitalization Program (SLH) recipients are medically necessary and appropriate. The SLH Program requires every participating acute care hospital to have in effect a plan for utilization review which applies to the inpatient services the facility furnishes to patients entitled to benefits under the SLH Program. The plan must provide for review of 100 percent of admissions, lengths of stays, professional services furnished, and each case of continuous, extended duration while the patient is in the facility.

CERTIFICATION AND RECERTIFICATION

Introduction

The SLH Program recognizes the physician as the key figure in determining the utilization of health services; the physician determines the appropriateness of admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. In recognition of this responsibility, the Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. The Program requires that payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished and, in certain instances, only if there is a physician's recertification as to the continued need for the covered services. The certification must be in writing and must be signed or initialed by an individual clearly identified as a physician (M.D.), doctor of osteopathy (D.O.), or a dentist (D.D.S.). The provider must date the certification at the time it is signed.

The provider of services must obtain the required physician certification and recertification statements and retain them on file for verification, when needed, by the intermediary or by the State agency.

Each provider of services determines the method by which the required physician certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, so long as the approach adopted by the provider permits verification that the requirement of physician certification and recertification, set forth in this part, is met.

Certification and recertification statements may be entered on or included in forms, notes, or other records a physician normally signs in caring for a patient, or a separate form may be used. Each certification and recertification statement must be separately signed by a physician, except as otherwise specified in this chapter. The requirements for recertification (and for certification for inpatient hospital services furnished), set forth in this chapter, specify certain information to be included in the physician's statement. This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate where the required information is contained in the patient's medical record. Providers of services must obtain timely hospital length of stay certifications and recertifications. However, delayed certifications and recertifications can be honored if, for example, the patient was unaware of his or her eligibility for SLH Program benefits when he or she was treated. Delayed certifications and recertifications must include or be accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant for explaining the delay. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Hospital Admission Certification and Plan of Care

Admission

The SLH Program requires a physician certification that inpatient hospital services are necessary for each hospitalized recipient. A physician must certify the need for inpatient care **at the time of admission**. The certification must be in writing and signed or initiated by a provider clearly identified as a physician (M.D.), doctor of osteopathy (D.O.), or dentist (D.D.S.). **The provider must date the certification at the time it is signed.**

The certification may be either a separate form to be included with the patient's records or a stamp stating "Certified for Necessary Hospital Admission" which is made an identifiable part of the physician orders, history, and physical, or other patient records. The provider must sign and date the certification at the time of admission or, if an individual applies for assistance while in the hospital, before payment is to be made by the State agency. Compliance is monitored on a regular basis by the Program's utilization review staff. Noncompliance may result in reimbursement being recouped.

For all inpatient services, the practitioner's documentation must justify the medical need for inpatient hospital services at the time of admission. Admission orders, a medical history, physical examination, presumptive diagnosis, and a detailed plan of care must be completed on the day of admission. The hospital must retain these items for review as the

Program deems necessary.

Plan of Care

The SLH Program requires that a written plan of care be established at the time of admission or before payment for care can be authorized for each recipient. The plan must be an identifiable part of the patient records and must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Any orders for medication, treatment, restorative, or rehabilitative services, activities, social services, and diet;
- Plans to continue care as appropriate;
- Estimated length of stay; and
- Tentative discharge plan.

Certification and Recertification for Recipient Receiving Retroactive Eligibility

If an individual receives services before his or her entitlement to the SLH Program benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. Example: If any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission.

UTILIZATION REVIEW ACTIVITIES

Introduction

In addition to the certification and recertification by the patient's own physician, the hospital must have a utilization review plan which provides for the review of **all** SLH Program patient stays and medical care evaluation studies of admissions, durations of stay, and professional services rendered. The objective of the utilization review mechanism is the maintenance of high-quality patient care and the most efficient utilization of resources through an educational approach

involving the study of patient care.
The objective of utilization review is to ensure that inpatient care is provided only when medically necessary and that the care meets quality standards.

The program requires that effective utilization review be maintained on a continuing basis to ensure the medical necessity of the services for which the Program pays and to promote the most efficient use of available health facilities and services.

Admission Review

The SLH Program delegates utilization review of inpatient hospital services for all SLH admissions to the local facilities' utilization review department. The SLH Program requires 100 percent utilization review of SLH patients. The hospital must have a utilization review plan reflecting 100 percent review of SLH patients. Agency staff will review the functions associated with approved hospital utilization review plans for compliance.

The hospital utilization review coordinator must approve the medical necessity, based on a list of admission criteria approved by the Utilization Review Committee, within one working day of admission. In the event of an intervening Saturday, Sunday, or holiday, a review must be performed the very next working day. The hospital utilization review plan and the patient's record must reflect this.

- If the admission is determined medically necessary, an initial stay review date must be assigned within the 50th percentile of norms approved by the Utilization Review Committee except in circumstances that are properly documented in the progress notes and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's Utilization Review Committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a Utilization Review Committee in one facility is not binding upon the Utilization Review Committee in another facility.

- If the admission or continued stay is found to be medically unnecessary, the attending physician must be notified and be allowed to present additional information. If the hospital physician advisor still finds the admission or continued stay unnecessary, a notice of adverse decision must be made within one working day after the admission or continued stay is denied. The Utilization Review Committee's designated agent must send copies of this decision to the hospital administrator, the attending physician, the recipient or the recipient's authorized representative, and the SLH

Program. Send the SLH Program notification to:

Supervisor, Payment Processing Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
ATTN: State/Local Hospitalization Program

Length-Of-Stay Monitoring Activity

The SLH Program will monitor the length of stay for inpatient hospital stays. The guidelines used will be based on 1984 (ICD-9-CM) diagnosis code data prepared by the Commission on Professional Hospital Activities (CPHA), Southern Region. A copy of the discharge summary, history and physical, and relevant patient progress notes must accompany claims with lengths of stays more than three days, exceeding the assigned percentile length-of-stay, any preoperative days, and weekend admissions (effective for dates of service on and after December 1, 1998). These claims will pend for review and appear under "pending" on the remittance voucher. A prepayment review of this documentation will focus on the necessity of admission and continued stay, discharge planning, and other Program requirements. If the stay or a portion of it is found to be medically unnecessary, contrary to Program requirements, or if the required documentation has not been received, the SLH Program will not make reimbursement.

Inpatient hospital stays for adults shall be limited to 21 days of covered hospitalization within 60 days for the same or similar diagnosis. The sixty-day period shall begin with the initial hospital admission. Only 21 total medically necessary days shall be covered whether incurred for one or more hospital stays, in the same or multiple hospitals, during the sixty-day period. Inpatient hospital admissions on Saturday and Sunday shall not be covered except in cases of medical emergencies (effective for dates of service on and after December 1, 1998). Reimbursement of inpatient hospital days on behalf of individuals under the age of 21 shall be for medically necessary stays in excess of 21 days as provided in the Virginia *State Plan for Medical Assistance*.

ABORTIONS

Induced or elective abortions are covered by the Virginia SLH Program upon the physician's certification that in his or her professional medical judgment the health of the recipient would be substantially endangered if the fetus were carried to term and that such judgment shall be exercised in light of all factors physical, emotional, psychological, familial, and the woman's age relevant to the well-being of the patient.

The policy statement does not pertain to the treatment of incomplete, missed, or septic abortions. Reimbursement for these types of abortions are covered.

The required certification must be documented in the patient's record. The required certification information for an elective abortion may be part of the physician's progress notes in the patient's record or a part of the admission history and physical. If a woman's life would be endangered by carrying the fetus to term, the attending physician must so certify; however, if this is not the case, but her health would nonetheless be substantially endangered, the attending physician certifies to that fact.

Physician certification must be attached to each invoice related to the induced abortion. Any hospital claim submitted without the appropriate certification will be denied. The hospital must secure a copy of the physician certification from the originating physician.

Reimbursement is available for those abortions performed during periods of **retroactive** eligibility if the physician certifies in writing that, on the basis of his or her professional judgment, **the life of the mother would have been endangered** if the fetus were carried to term. The certification must contain the name and address of the patient and the recipient's ID number.

ICD-9-CM Abortion Procedure Codes*

6350-6359	Legally induced abortion
6370-6379	Unspecified abortion
6380-6389	Failed attempt abortion
6901	Aspiration curettage for termination of pregnancy
6951	Aspiration curettage of uterus for termination of pregnancy—therapeutic abortion NOS
7491	Hysterectomy to terminate pregnancy—therapeutic abortion by hysterectomy
750	Intra-amniotic injection for abortion—injection of prostaglandin or saline for induction of abortion—termination of pregnancy by intrauterine injection
7796	Termination of pregnancy (fetus)
9649	Other genitourinary instillation

Excludes: 73.1 Other surgical induction of labor and 73.4 Medical induction of labor

*Note: The codes that define abortion procedures refer to legal abortions only. These procedures must meet specific criteria to receive SLH Program funds. Any medical treatment as a result of an abortion is considered a medical service and not subject to funding restrictions.

STERILIZATIONF

Human Reproductive Sterilization

The SLH Program defines human reproductive sterilization as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Sterilizations that are performed because pregnancy would be life-threatening to the mother (so-called "therapeutic" sterilizations) are included in this definition. The term sterilization means only human reproductive sterilization as defined above.

Conditions of Coverage

The SLH Program will cover a sterilization only if the following conditions are met:

- The individual is at least 18 years old at the time consent for sterilization is obtained.

  Note: A patient must be 18 years old to give consent to a sterilization. This is a State requirement found in the *Code of Virginia* §54.1-2974 et.seq. for **sterilizations only** and is not affected by any other State law regarding the ability to give consent to medical treatment generally. The age limit is an **absolute** requirement. There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

- The individual is not mentally incompetent. For SLH Program purposes, a mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. The competency requirement is an **absolute** requirement. There are no exceptions.
- The procedure has not been court-ordered.

- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form as required by the individual hospital if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure. This form must be signed by the physician and witnessed.

- The individual is not institutionalized. For the purposes of the SLH Program reimbursement for sterilization, an institutionalized individual is a person who is:

    - Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or

    - Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

- The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section. At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of the sterilization, except in the following instances:

    - Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent to be sterilized was given.

    - Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at least 30 days before the expected date of the delivery and at least 72 hours have passed after written informed consent to be sterilized was given.

- A completed consent form must accompany all claims for sterilization services.

Sterilization is covered only if all applicable requirements are met. These include:

- The time period required between the date of informed consent and the date of sterilization;

- The informed consent requirements for the individual seeking sterilization; and

- The certification requirements for signatures of the individual seeking sterilization, the interpreter (if applicable), the person obtaining consent, and the physician who performed the sterilization procedure that must be present on the form.

Previously provided sterilization services cannot be billed unless the applicable requirements have been met.

Informed Consent Process of Sterilization

The informed consent process may be conducted either by a physician or by the physician's designee.

An individual has given informed consent only if:

- The person who obtained consent for the sterilization procedure:

    - Offered to answer any questions the individual may have had concerning the sterilization procedure;

    - Provided the individual with a copy of the consent form;

    - Provided orally all of the following information to the individual to be sterilized:

        - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any State-funded program benefits to which the individual might be otherwise entitled;

        - A description of available alternative methods of family planning and birth control;

        - Advice that the sterilization procedure is considered to be irreversible;
        - A thorough explanation of the specific sterilization procedure to be performed;

- A full description of the discomforts and risks that may accompany or follow performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

- A full description of the benefits or advantages that may be expected as a result of the sterilization; and

- Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery, in which case 72 hours must have passed between the informed consent and surgery; also, in the case of premature delivery, consent must have been given at least 30 days prior to the expected date of delivery.

- Suitable arrangements were made to ensure that the information specified above was effectively communicated to the blind, deaf, or otherwise handicapped individual to be sterilized.

- An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining the consent.

- The individual to be sterilized was permitted to have a witness of the individual's choice present when consent was obtained.

- The sterilization operation was requested without fraud, duress, or undue influence.

- All other State and local requirements were followed.

- The appropriate consent form was properly filled out and signed.

Informed consent may not be obtained while the individual to be sterilized is:

- In labor or within 24 hours postpartum or postabortion;

- Under the influence of alcohol or other substances that affect the individual's state of awareness; and

- Seeking to obtain or obtaining an abortion

- "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made.

- "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

NOTE: The *Code of Virginia* §54.1-2974 et.seq. prohibits the giving of consent to a sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.

Sterilization Consent Document

A sterilization consent document is acceptable from each hospital or facility meeting the State's legal requirements. An informed consent does not exist unless the required sterilization form is completed voluntarily by a person 18 years of age or older and in accordance with the following requirements. No payment will be made without the submission of a form completed, signed, and dated by the patient giving the consent, the person obtaining the consent, and the physician who performed the surgery. The date of the signature of the person obtaining an informed consent must be the same as the date of the signature of the person giving consent.

Use of the Consent Form

The consent form must be signed and dated by the following:

- The individual to be sterilized;

- The interpreter (if one is required);

- The individual who obtains the consent; and

- The physician who will perform the sterilization procedure.

The person obtaining consent shall certify by signing the consent form that he or she:

- Advised the individual seeking sterilization, before the individual signed the consent form, that no benefits may be withheld or withdrawn because of the decision not to be sterilized;

- Explained orally the requirements for informed consent to the individual seeking sterilization as set forth on the consent form and in regulations; and

- Determined to the best of his or her knowledge and belief that the individual seeking sterilization appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The physician performing the sterilization shall certify by signing the consent form that:

- The physician, shortly before the performance of the sterilization, advised the individual seeking sterilization that benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (For SLH Program purposes, the phrase "shortly before" means a period within 72 hours prior to the time the patient receives any preoperative medication.)

- The physician explained orally the requirements for informed consent as set forth on the consent form.

- To the best of the physician's knowledge and belief, the individual seeking sterilization appeared to be mentally competent and knowingly and voluntarily consented to be sterilized.

- At least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed, except in the following instances:

    - Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least 30 days before he or she was scheduled to be sterilized; that at least 72 hours have passed after written informed consent to be sterilized was given; and the physician describes the emergency on the consent form.

    - Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the

expected date of the delivery and at least 72 hours have passed after written informed consent of the individual seeking sterilization was given. The physician shall state the expected date of the delivery on the consent form.

The interpreter, if one is provided, shall certify by signing the consent form that he or she:

- Communicated the information and advice in a manner understandably presented to the individual seeking sterilization;
- Read the consent form and explained its contents to the individual seeking sterilization; and
- Determined to the best of his or her knowledge and belief that the individual seeking sterilization understood what the interpreter communicated to the individual.

A copy of the signed consent form must be:

- Provided to the patient;
- Retained by the physician and the hospital in the patient's medical records; and
- Attached to the hospital's claim for the sterilization services.

Only claims directly related to the sterilization surgery require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

ICD-9-CM Sterilization Procedure Codes

624	Bilateral orchidectomy
6241	Removal of both testes at the same operative episode
6242	Removal of remaining testis
637	Vasectomy and ligation of vas deferens
6370	Male sterilization procedure, not otherwise specified

6371	Ligation of vas deferens
6372	Ligation of spermatic cord
6373	Vasectomy
6550	Bilateral oophorectomy
6551	Other removal of both ovaries at same operative episode
6552	Other removal of remaining ovary
6553	Laparoscopic removal of both ovaries at same operative episode
6554	Laparoscopic removal of remaining ovary
6560	Bilateral salpingo-oophorectomy
6561	Other removal of both ovaries and tubes at same operative episode
6562	Other removal of remaining ovary and tube
6563	Laparoscopic removal of both ovaries and tubes at same operative episode
6564	Laparoscopic removal of remaining ovary and tube
6620	Bilateral endoscopic destruction or occlusion of fallopian tubes—includes bilateral endoscopic destruction or occlusion of fallopian tubes by culdoscopy, endoscopy, hysteroscopy, laparoscopy, peritoneoscopy, or endoscopic destruction of solitary fallopian tube
6621	Bilateral endoscopic ligation and crushing of fallopian tubes
6622	Bilateral endoscopic ligation and division of fallopian tubes
6629	Other bilateral endoscopic destruction or occlusion of fallopian tubes
6630	Other bilateral destruction or occlusion of fallopian tubes

6631	Other bilateral ligation and crushing of fallopian tubes
6632	Other bilateral ligation and division of fallopian tubes
6639	Other bilateral destruction or occlusion of fallopian tubes
6650	Total bilateral salpingectomy
6651	Removal of both fallopian tubes at same operative episode
6652	Removal of remaining fallopian tube
6660	Other salpingectomy
6663	Bilateral partial salpingectomy; not otherwise specified
6669	Other partial salpingectomy

Retroactive Coverage

Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician certifies on the DMAS-3005 or the hospital's consent form that one of the following conditions was met:

- The physician informed the recipient before the operation that the procedure would make her sterile. In this case, the patient and the physician must sign the DMAS-3005 or the hospital's consent form.

- The recipient met one of the exceptions provided in the Physician Statement Section of the DMAS-3005 or the hospital's consent form. In this case, no recipient signature is required.

OTHER UTILIZATION REVIEW ACTIVITIES

Documentation Guidelines

The following guidelines are presented to assist in reducing the number of claim denials by the SLH Program due to missing, inadequate, or inappropriate documentation.

Guidelines for Submission of Documentation

Invoices with the following conditions will pend for review. Documentation which will justify each pended condition must accompany the invoice.

Weekend Admission

For a length of stay of three days or less, place the justification for admission and treatment provided in locator 94 of the UB-92 HCFA-1450 invoice (effective for dates of service on and after December 1, 1998). Do not attach further justification unless this space is not adequate or the claim will pend for reason(s) requiring specific documentation, such as consent forms. For a length of stay of four days or more, the history and physical, physician progress notes, physician orders, and discharge summary are required.

Preoperation Days

The history and physical, physician progress notes, physician orders, and discharge summary are required (effective for dates of service on and after December 1, 1998).

Length of Stay More Than Three Days

The history and physical, physician progress notes, physician orders, and discharge summary are required (effective for dates of service on and after December 1, 1998).

Length of Stay Exceeds Percentile Limit

The history and physical, physician progress notes, physician orders, and discharge summary are required.

Sterilization, Hysterectomy, and Abortions

The specialty forms for the above-referenced procedures (DMAS-3004—DMAS Sterilization Form, DMAS-3005—DMAS Hysterectomy form, or the Hospital's Surgical Consent Form for Hysterectomy, or DMAS-3006—Abortion Certification Form), history and physical, physician progress notes, and discharge summary are required. Length-of-stay requirements must also be met.

Length of Stay 21 Days or Greater and Client Is Under 21 Years of Age

With the first invoice, the history and physical, physician orders, and physician progress notes are required.

With all subsequent invoices for continued stays, only the physician progress notes and physician orders are needed for the continued billing period. The discharge summary is required with the last invoice.

Surgeries Listed on Mandatory Outpatient Procedures Performed as Inpatient

The history and physical physician progress notes, and discharge summary are required (see Appendix B).

When sending documentation with inpatient claims, the documentation must be attached to the invoice. If the SLH Program utilization review analyst assigned to the hospital requires additional documentation, it will be noted on a Department of Medical Assistance Services (DMAS) request. This letter will specify the particular documentation needed and will be sent to the representative designated by each hospital. When responding to the request, return the request letter attached to the documentation. DMAS must receive documentation no later than the 20th day from the date of the request letter. If the documentation is not received by the 20th day, the claim will be denied for the reason "Requested Information Not Received." These denied invoices will be returned to the designated utilization review representative with the original documentation and the original request letter identifying the additional documentation requested. To resubmit these claims, attach the additional documentation to the original invoice along with the original documentation. The original invoice may be used by covering the reference number with correction tape.

Contact the SLH utilization review analyst assigned to the hospital if there are any questions regarding documentation to be sent with inpatient hospital claims. The Payment Processing Unit telephone number is (804) 786-0194.

Provider Appeals

The hospital Utilization Review Committee must hear appeals regarding the medical necessity of admissions, continued stays, outpatient emergency services, and other services. DMAS will hear appeals concerning the denial of payment by DMAS.

Send requests for consideration of denied hospital days or emergency room services with additional supporting documentation to:

Department of Medical Assistance Services
Attn: Payment Processing Unit
600 East Broad Street, Suite 1300

Richmond, Virginia 23219